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Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING. B. WING TN1916 02/07/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3939 HILLSBORO CIRCLE GREEN HILLS CENTER FOR REHABILITATION NASHVILLE, TN 37215 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) N 000, Initial Comments N 000 The licensure survey and complaint investigation #TN00050307 were completed on 2/7/2020 at Green Hills Center for Rehabilitation and Healing. Deficiencies were cited related to the licensure survey under Chapter 1200-8-6, Standards for Nursing Homes. N 682 1200-08-06-.06(4)(f) Basic Services N 682 N682 1200-08-06-.06(4)(f) Basic Services (4) Nursing Services. See F 656 (f) The facility must ensure that an appropriate individualized plan of care is prepared for each resident with input from appropriate disciplines. the resident and/or the resident 's family or the resident 's representative. This Rule is not met as evidenced by: Based on facility policy review, medical record review, observation, and interview the facility failed to develop and implement a person-centered care plan for 3 of 41 residents (Resident #60, #4 and #57) reviewed for Comprehensive Care Plans placing the residents in Immediate Jeopardy (IJ) (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident). Resident #60 experienced a fall which resulted in a C7 fracture (fracture of the 7th neck vertebra) and a second fall which resulted in a Proximal Left Hip Fracture (Fracture at the base of the Femoral Neck). Resident #4 experienced a fall which resulted in a Traumatic Subarachnoid Hemorrhage (bleeding in the space between the brain and the tissue covering the brain related to trauma). Resident #4 then developed a new onset of seizure activity after ivision of Health Care Facilities

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: TN1916 B. WING 02/07/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3939 HILLSBORO CIRCLE GREEN HILLS CENTER FOR REHABILITATION NASHVILLE, TN 37215 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) N 682 Continued From page 1 N 682 the fall. Resident #57 was left unattended in the bathroom, fell while self-toileting and sustained a Left Humerus (upper arm) Fracture. The Administrator was notified of the Immediate Jeopardy (IJ) on 2/4/2020 at 10:05 PM in the Director of Nursing's (DON) office. N-682 1200-806-.06(F) was cited at a scope and severity of "K". An extended survey was conducted from 2/4/2020 through 2/7/2020. The Immediate Jeopardy was effective from 7/3/2019 to 2/6/2020 An Immediate Action Removal plan which removed the immediacy of the jeopardy was received on 2/7/2020 at 12:30 PM and corrective actions were validated on site by the surveyors on 2/7/2020. The findings include: Review of the medical record, revealed Resident #60 was admitted to the facility on 3/14/2016 with diagnoses which included History of Falling, Dementia without Behavior Disturbance and Difficulty in Walking. Further review showed the resident was readmitted on 7/5/2019 with a new diagnosis of Displaced Fracture of Seventh Cervical Vertebra (C7 Fracture), Unsteadiness on Feet and Orthostatic Hypotension. Continued review showed a new diagnosis was added on 12/1/2019, Unspecified Fall. Further review showed a new diagnosis was added on 12/24/2019, Displaced Fracture of Base of Neck of Left Femur (L Proximal Hip Fracture).

Division of Health Care Facilities

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	For The Unit Record at Rec	Review of the Quarte (MDS) dated 4/9/201 had severe cognitive highly impaired, he reambulation and most (ADLs) and required transferring from a chwith one person phys  Review of the fall risk 3/15/2019, and 4/9/20 was assessed at a high Review of Resident #6 Plan revealed no interwith ambulation per M Review of the interdisc dated 7/3/2019, he was found the floor in another resinwitnessed"  Review of the fall risk as 1/0/2019 and 12/1/20 ontinued to be at high eview of Resident #60 omprehensive Care Pointerventions for suppler the falls on 7/3/20 eview of the fall risk as 1/6/2019, revealed Reshigh risk for falls.	erly Minimum Data Set 9, revealed Resident #60 impairment, his vision is equired supervision with to other activities of daily living limited assistance with hair to a standing position ical assistance.  assessment dated 219, revealed Resident #60 gh risk for falls.  60's Comprehensive Care ventions for supervision DS dated 4/9/2019.  ciplinary post fall review ed "Resident #60 fell on d in a supine position on ident's roomthe fall was  assessment dated 19, revealed Resident #60 risk for falls.  O's undated Plan revealed there were ervision with ambulation 19 and 12/23/2019.  ssessment dated sident #60 continued to be  MDS assessment dated sident #60 had severe	N 682			

ision of Health Care Facilities

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: TN1916 B. WING 02/07/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3939 HILLSBORO CIRCLE GREEN HILLS CENTER FOR REHABILITATION NASHVILLE, TN 37215 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **DEFICIENCY**) N 682 Continued From page 3 N 682 assistance with most of his ADLs. Review of the interdisciplinary post fall review dated 12/24/2019, revealed Resident #60 had an unwitnessed fall on 12/23/2019. The resident was found in the doorway of another resident's room. Review of Resident #60's Comprehensive Care Plan interventions revealed no interventions for the resident requiring 1 person assistance with ambulation were added after the fall on 12/23/2019. Review of Resident #60's radiology report dated 12/24/2019, revealed "... Proximal left hip fracture..." Review of the MDS Comprehensive Assessment on 1/3/2020, revealed Resident #60 had severe cognitive impairment, his vision was highly impaired, and he needed extensive assistance with all of his ADL, and walking activity did not occur. The resident had a fall with major injuries and was referred to hospice services post fall. Observation on 2/4/2020 at 8:42 AM, revealed Resident #60 was sitting up in his wheelchair in the day room, his eyes were open, but he did not interact with others. During an interview on 2/5/2020 at 4:45 PM, Certifled Nursing Assistant (CNA) #4 stated after the fall on 12/23/2019, "...Resident #60 had a drastic change in functional status..." During an interview on 2/6/2020 at 3:15 PM. Registered Nurse (RN) #3 stated Resident #60 had a fall on 12/23/2020, which resulted in a Left Hip Fracture. During continued interview RN #3 stated the resident was unable to ambulate after

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING: \_ B. WING TN1916 02/07/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3939 HILLSBORO CIRCLE GREEN HILLS CENTER FOR REHABILITATION NASHVILLE, TN 37215 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) N 682 Continued From page 4 N 682 the fall. Review of the medical record revealed Resident #4 was admitted to the facility on 4/16/2019, with diagnoses which included Dementia without Behavior Disturbance and Altered Mental Status. Further review showed the resident was readmitted on 10/10/2019, with new diagnoses of Traumatic Subarachnoid Hemorrhage and Post Traumatic Seizures. Continued review showed a new diagnosis for Repeated Falls was added on 11/11/2019. Review of the Quarterly Minimum Data Set (MDS) dated 4/24/2019, revealed Resident #4 was rarely or never understood, locomotion on the unit required extensive assistance with a 2 person physical assistance; and walking in room did not occur. Review of the fall risk assessments dated 4/10/2019, 4/27/2019, and 7/23/2019, revealed Resident #4 was at high risk for falls. Review of the post fall reports revealed Resident #4 had an unwitnessed fall on 7/23/2019, with no injuries. Review of the Comprehensive Care Plan for Resident #4 revealed no interventions for supervision and assistance with ambulation. Review of the Quarterly MDS dated 7/25/2019. revealed Resident #4 was rarely or never understood and walking in the room and corridor required supervision. Review of the fall risk assessment dated 7/25/2019, and 10/7/2019, revealed Resident #4

continued to be at high risk for falls.

FORM APPROVED Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING TN1916 02/07/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3939 HILLSBORO CIRCLE GREEN HILLS CENTER FOR REHABILITATION NASHVILLE, TN 37215 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) N 682 Continued From page 5 N 682 Review of the post fall interdisciplinary review dated 10/8/2019, revealed "...Resident #4 had a fall with injuries on 10/7/2019 which resulted in Traumatic Subarachnoid Bleed..." Review of the Comprehensive Care Plan revealed the following intervention was added on 10/7/2019, "...Transfer to ER [emergency room] for further evaluation and treatment as indicated..." Review of the fall risk assessment dated 10/10/2019, revealed Resident #4 continued to be at high risk for falls. Review of the Quarterly MDS dated 10/25/2019 revealed Resident #4 was rarely or never understood and ambulation in the room and in the corridor required supervision with 1 person physical assistance. Review of Resident #4's Comprehensive Care Plan revealed no interventions for supervision or assistance with ambulation were added after the following falls: 7/23/2019, 10/7/2019 and 11/10/2019. Review of the Interdisciplinary Post Fall Review dated 11/10/2019, revealed Resident #4 had an unwitnessed fall on 11/10/2019. Review of the fall risk assessment dated 11/18/2019, revealed Resident #4 continued to be at high risk for falls. During an interview on 2/5/2020 at 3:18 PM,

Nurse Practitioner #1 confirmed Resident #4's fall on 10/7/2019, was unwitnessed. There were no neurological changes before the fall and he did

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: TN1916 B WING \_ 02/07/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3939 HILLSBORO CIRCLE GREEN HILLS CENTER FOR REHABILITATION NASHVILLE, TN 37215 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) N 682 Continued From page 6 N 682 not have a history of seizures prior to his fall on 10/7/2019. Review of the medical record revealed Resident #57 was admitted to the facility on 7/17/2019, with diagnoses which included Dementia Without Behavioral Disturbances, Major Depressive Disorder, Bipolar Disorder, Hemiplegia and Hemiparesis Following Cerebral Infraction Affecting Left Non-Dominant Side, and Dysphagia. Review of Resident #57's comprehensive care plan dated 7/18/2019, revealed "...I require Mechanical Lift with 2 staff assistance for transfers... I need moderate asst. (assistance) from one person to toilet...I need moderate asst. (assistance) to perform hygiene..." Review of Resident #57's Quarterly Minimum Data Set (MDS) dated 12/21/2019, revealed Resident #57 had a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. Further review revealed Resident #57 required extensive assistance with 1 person physical assist with transfers, toileting use, and personal hygiene. Review of Resident #57's Significant Change MDS dated 1/3/2020, revealed Resident #57 had a BIMS score of 3, indicating severe cognitive impairment. Further review revealed Resident #57 required extensive assistance with 1 person physical assist with transfers, major injury since admission. Review of Resident #57's Interdisciplinary Post Fall Review dated 12/24/2019, revealed "...unwitnessed fall...resident was attempting to wipe herself after a bowel movement...resident

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NAME OF PROVIDER OR SUPPLIER  TN1916  STREET ADDRESS, CITY, STATE, ZIP CODE  3939 HILLSBORD CIRCLE  NAME OF PROVIDER OR SUPPLIER  GREEN HILLS CENTER FOR REHABILITATION  SYMPHALE, TN 37215  (EACH DEPTICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  N 682  N 682  Continued From page 7  found on the floor of the bathroom when Certified Nursing Assistant (CNA) #2 returned to the room"  Review of Resident #57's fall report dated 12/24/2019 revealed "patient tried to stand up to wipe herself after having a bowel movement and fellgait imbalanceunaware of physical limitationshistory of fallsfinamed CNA 2 was educated per [by] the Unit Manager regarding the importance of staying near the bethroom or outside the door to promote safety while providing privacy"  During a telephone interview on 2/4/2020 at 8:39  PM, CNA #2 stated she assisted Resident #57 to the bathroom without the use of a mechanical lift or anyone else. During shift change I was verbally briefed by outgoing staff (Resident #57 was a 1 person physical assist for tolleting." During onthinued interview, CNA #2 stated "relied on outgoing staff to brief me on the residents care needs were for the shift. I didn't look at her care plan.  During an interview on 2/5/2020 at 6:30 PM with the Director of Nursing (DON), Administrator, they stated they believed the care plan interventions in place for 3 Residents (#4, #57 and #80) were adequate to keep these residents safe.  The Immediate Action Removal Plan was verified by the surveyors on 2/7/2020 by:  1. The surveyors verified through review of care plans and staff interviews the care plan and staff interviews the care plan.	Divisio	on of Health Care Fac	ilities			TOMMATINOVED
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Nursing Assistant [CNA] #2 returned to the room"  Review of Resident #57's fall report dated 12/24/2019 revealed "patient tried to stand up to wipe herself after having a bowel movement and fellgait imbalanceunaware of physical limitationshistory of fallsfnamed CNA 2] was educated per [by] the Unit Manager regarding the importance of staying near the bathroom or outside the door to promote safety while providing privacy"  During a telephone interview on 2/4/2020 at 8:39 PM, CNA #2 stated she assisted Resident #57 to the bathroom on 12/24/2019. She stated, "At the request of the resident, I assisted her to the bathroom without the use of a mechanical lift or anyone else. During shift change I was verbally briefed by outgoing staff [Resident #57] was a 1 person physical assist for briefing." During continued interview, CNA #2 stated "I relied on outgoing staff to brief me on the residents care needs or I ask a resident what their care needs were for the shift. I didn't look at her care plan."  During an interview on 2/5/2020 at 6:30 PM with the Director of Nursing (DON), Administrator, they stated they believed the care plan interventions in place for 3 Residents (#4, #57 and #60) were adequate to keep these residents safe.  The Immediate Action Removal Plan was verified by the surveyors on 2/7/2020 by:  1. The surveyors verified through review of care plans and staff interviews the care plan.	N 682	Continued From pag	ne 7	N 682		2÷
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interventions were implemented for Residents #4, #57 and #60. Resident #4's Care Plan was was	by 1. pla int	the surveyors on 2/7 The surveyors verifie ans and staff intervieverventions were imple	/2020 by:  d through review of care /s the care plan emented for Residents #4,			

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING TN1916 02/07/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3939 HILLSBORO CIRCLE GREEN HILLS CENTER FOR REHABILITATION NASHVILLE, TN 37215 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) Continued From page 8 N 682 N 682 updated to reflect staff will offer assistance with ambulation. Resident #57's Care Plan was updated to reflect she required moderate assistance with toileting. Resident #60's Care Plan was updated to include bilateral fall mats when in bed and bed in low position. 2. The surveyors verified all safety interventions were in place for 3 residents (#4, #57 and #60). The surveyors verified the facility's 100% audit of residents who were at risk for falls and reviewed the care plans for the residents at risk. 3. The surveyors reviewed and verified the Fall Prevention and ADL's/Functional Status education and training was completed for the Certified Nursing Assistants who were present (90% of the CNA staff) on 2/6/2020. The remaining 10% will receive education by 2/10/2020. The surveyors verified the facility held an AdHoc/QAPI meeting (an immediate meeting by Administrative staff to address the immediate situation) on 2/5/2020 to include discussion related to fall prevention and care plan implementation. The facility's noncompliance at F-656 continues at a scope and severity of "E" for the monitoring of the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction. N1102 1200-8-6-.11(2) Records and Reports N1102 1200-8-6-.11(2) Records and Reports N1102 3/2/20 .See F609 (2) The nursing home shall report all incidents of abuse, neglect, and misappropriation to the Department of Health in accordance with T.C.A. §

ision of Health Care Facilities

68-11-211.

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Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING. TN1916 02/07/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3939 HILLSBORO CIRCLE GREEN HILLS CENTER FOR REHABILITATION NASHVILLE, TN 37215 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) N1102 Continued From page 9 N1102 This Rule is not met as evidenced by: Based on facility policy review, medical record review and interview, the facility failed to report resident to resident altercations to the state agency for 4 of 4 resident to resident altercations reviewed. The findings include: Review of the facility policy titled, Abuse and Neglect Prohibition, revised August 2017, revealed "... The facility will report all allegations and substantiated occurrences of abuse, neglect. exploitation, mistreatment including injuries of unknown origin, and misappropriation of property to the administrator, State Survey Agency, and law enforcement officials and adult protective services (where state law provides for jurisdiction in long-term care facilities) in accordance with Federal and State law through established procedures..." Review of the medical record, revealed Resident #4 was admitted to the facility on 4/16/2019 and readmitted on 10/10/2019 with diagnoses which included Alzheimer's Disease. Altered Mental Status and Dementia. Review of Resident #4's nurses progress note dated 7/23/2019 revealed the resident was involved in an altercation with an unnamed resident. Review of the medical record, revealed Resident #13 was admitted to the facility on 10/30/2018

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: COMPLETED B. WING TN1916 02/07/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3939 HILLSBORO CIRCLE GREEN HILLS CENTER FOR REHABILITATION NASHVILLE, TN 37215 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) N1102 Continued From page 10 N1102 with diagnoses which included Altered Mental Status, Cognitive Communication Deficit, Vascular Dementia without Behavioral Disturbances and Anxiety. Review of Resident #13's nurses progress note dated 11/26/2019 revealed the resident was involved in two altercations with an unnamed resident. Review of the medical record, revealed Resident #60 was admitted to the facility on 3/14/2016 with diagnoses which included Unspecified Dementia without Behavioral Disturbance, History of falling and difficulty in walking. Review of Resident #60's nurses progress notes revealed the resident was involved in an altercation with an unnamed resident on 10/21/2019 and 11/21/2019. Review of the medical record, revealed Resident #173 was admitted to the facility on 2/6/2019 with diagnoses which included Heart Failure, Anemia, Osteoarthritis, Peripheral Disease and Weakness. Review of Resident #173's nurses progress note revealed the resident was involved in an altercation with an unnamed resident on 4/8/2019. During an interview on 2/5/2020 at 5:30 PM, the Director of Nursing (DON) and the Administrator confirmed the facility had not reported any resident to resident altercations to the state agency in 2 years.

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: TN1916 B. WING 02/07/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3939 HILLSBORO CIRCLE GREEN HILLS CENTER FOR REHABILITATION NASHVILLE, TN 37215 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) N1207 Continued From page 11 N1207 N1207 1200-8-6-.12(1)(g) Resident Rights N1207 1200-8-6-.12(1)(g) Resident Rights N1207 3/2/20 See F550 (1) The nursing home shall establish and implement written policies and procedures setting forth the rights of residents for the protection and preservation of dignity, individuality and, to the extent medically feasible, independence. Residents and their families or other representatives shall be fully informed and documentation shall be maintained in the resident's file of the following rights: (g) To be free from mental and physical abuse. Should this right be violated, the facility must notify the department within five (5) working days. The Tennessee Department of Human Services. Adult Protective Services shall be notified immediately as required in T.C.A. §71-6-103; This Rule is not met as evidenced by: Based on facility policy review, medical record review, and interview, the facility failed to ensure 3 of 4 sampled residents (Resident #4, #13, and #60) reviewed involved in resident to resident altercations were free from abuse. The findings include: Review of the facility policy titled, Abuse and Neglect Prohibition, revised August 2017, revealed "... Each resident has the right to be free from abuse, neglect, mistreatment, injuries of unknown origin, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms..."

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: TN1916 B. WING 02/07/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3939 HILLSBORO CIRCLE GREEN HILLS CENTER FOR REHABILITATION NASHVILLE, TN 37215 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) N1207 Continued From page 12 N1207 #4 was admitted to the facility on 4/16/2019 and readmitted on 10/10/2019 with diagnoses which included Alzheimer's Disease, Altered Mental Status and Dementia. Review of Resident #4's nurses progress note dated 7/23/2019 revealed "...Resident yelled out, as he was on the floor in room lying on his back. This writer asked resident B what happened, and he stated that he pushed him. When asked why did he do that, resident B stated that resident A pushed him first..." Review of the medical record, revealed Resident #60 was admitted to the facility on 3/14/2016 with diagnoses which included Unspecified Dementia without Behavioral Disturbance, History of falling and difficulty in walking. Review of Resident #60's nurses progress note dated 10/21/2019 revealed "...Pt [patient] was found in his room sitting quietly when another resident was witnessed going into this residents room and kicked him in the groin..." Review of Resident #60's nurses progress note dated 11/21/2019 revealed "...Resident was in his room lying in bed when was struck in the abdomen by another resident who purposefully came into room..." Review of the medical record, revealed Resident #173 was admitted to the facility on 2/6/2019 with diagnoses which included Heart Failure, Anemia, Osteoarthritis, Peripheral Disease and Weakness. Review of Resident #173's nurses progress note dated 4/8/2019 revealed "...Resident came into close proximity to an agitated resident to probably

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		between dementia residents ad not reported any resident to			
	resident altercation	to the state agency in the last			T .
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